

symmetrically, so as to give the greatest possible strength. In all cases the best and most durable part of the nose is the nasal cartilage, which is easily obtained by the division of the nose, and is easily preserved. The following is a brief account of the operations performed at the Philadelphia Academy of Surgery during the year 1903.

## TRANSACTIONS

*OF THE PHILADELPHIA ACADEMY OF SURGERY.*

1903-1904.

THE ANNUAL MEETING.

*Stated Meeting, January 4, 1904.*

The President, RICHARD H. HARTE, M.D., in the Chair.

DR. G. GWILYMD. DAVIS, delivered an address on the subject of **RHINOPHYMA**.

DR. W. W. KEEN presented a man who had been subjected to operation for the relief of rhinophyma. For the account of the case, with remarks upon it, see page 665.

### THE TREATMENT OF FRACTURES.

DR. GWILYMD. DAVIS delivered an address on this subject, this being the Annual Address in Surgery, for which see page 778.

DR. W. W. KEEN took exception to the writer's commendation of the use of silicate of soda or starch as primary dressings. They will not hold the parts in place until the dressing hardens, and hence allow displacement of fragments. Dr. Davis had also spoken of plaster-of-Paris dressings, but did not specify the mode of their application. If applied simply by circular turns, then they are open to objections, such as interfering with proper cleansing of the parts, massage, etc. If they are applied as splints, they can be used as a fixed dressing, and still be removed to allow of access to the parts. Dr. Keen has recently seen a new form of plaster splint, his attention having been directed to it by Mr. Rebman, of London. It consists practically of a bag one metre in length and from two or three to five or six fingers wide. This is impregnated with plaster, a mesh passing down in the centre to give stability. One can take any amount, six inches to two or more feet, put it in water, prepare it properly, and apply as a

splint. It adapts itself readily to the surface with which it is placed in contact; and thus furnishes a reliable support. This splint is the idea of Dr. Sahli, of Berne. Dr. Keon was glad to hear Dr. Davis speak words of caution regarding the injudicious use of passive motion in the treatment of fractures. In his early career he had under his care cases of Colles's fracture in which he wished to employ passive motion. This he did by flexing the fingers until the hand was made into a fist and then bending the wrist. If any one will try this manipulation, he will readily see what a small amount of flexion of the wrist can be given without causing pain even in a normal hand. If the fingers are straightened, the wrist can be flexed to a right angle with no pain. The surgeon too often forgets the normal limit of movement when he is using passive motion in a fractured limb.

DR. OSCAR H. ALLIS said that Dr. Davis had in his address furnished enough material for a half-dozen or more papers. Any one point, such as treatment of fracture of the thigh or elbow, or massage in the treatment of fractures, would have been sufficient for discussion. He wished to speak regarding simple fractures of the femur. These fractures may be produced in one of three ways: (1) when the force is exerted at right angles to the long axis of the bone; (2) when the force is parallel or in the direction of the long axis; (3) by twisting. In many instances there is an independent fragment of bone. In oblique and especially in spiral fractures where the forces meet there will be found towards the central part of the bone one or more small fragments. In the X-ray we have a valuable adjunct in making a diagnosis. If the surgeon will make use of this and find the exact condition of the injured part, he will enter upon his work in caring for it with far more assurance. It is too true, even lamentably true, that surgeons do not often enough open joints when dealing with fractures that extend into them. In the case of fractures into the knee-joint, the semilunar cartilages may be torn or twisted out of their place, or the crucial ligaments be torn and form practically foreign bodies. Even if the fragments are brought together, there is often a lack of good results in these cases, because the torn structures are pinched between the bones. It should be almost an axiom in fractures involving a joint to open and remove any spicules that may be present. The prevention of angular deformity following fractures of the upper part of the femur is

one of the most difficult problems in all surgery. When the fracture is oblique and can be wired above and below, fixation is possible. When the fracture is transverse, deformity is almost sure to follow even when wiring is resorted to.

DR. DAVIS, in closing, said that it was a very difficult question what to include and what to exclude. He had avoided the discussion of individual fractures and confined his address to the consideration of principles. Regarding Dr. Keen's reference to silicate of soda and starch, he thought there was a misapprehension, as he had not intended to advocate their use as primary fixed dressings. The silicate of soda takes twenty-four hours to harden, and is not immediately adapted to hold bony fragments in position. At the end of ten days, when the parts are fairly firm, this dressing may be used. Starch is not so firm as the former, but helps to keep the turns of a bandage in position and prevents slipping. When plaster-of-Paris is used as detailed by Dr. Keen, it resembles an ordinary splint.